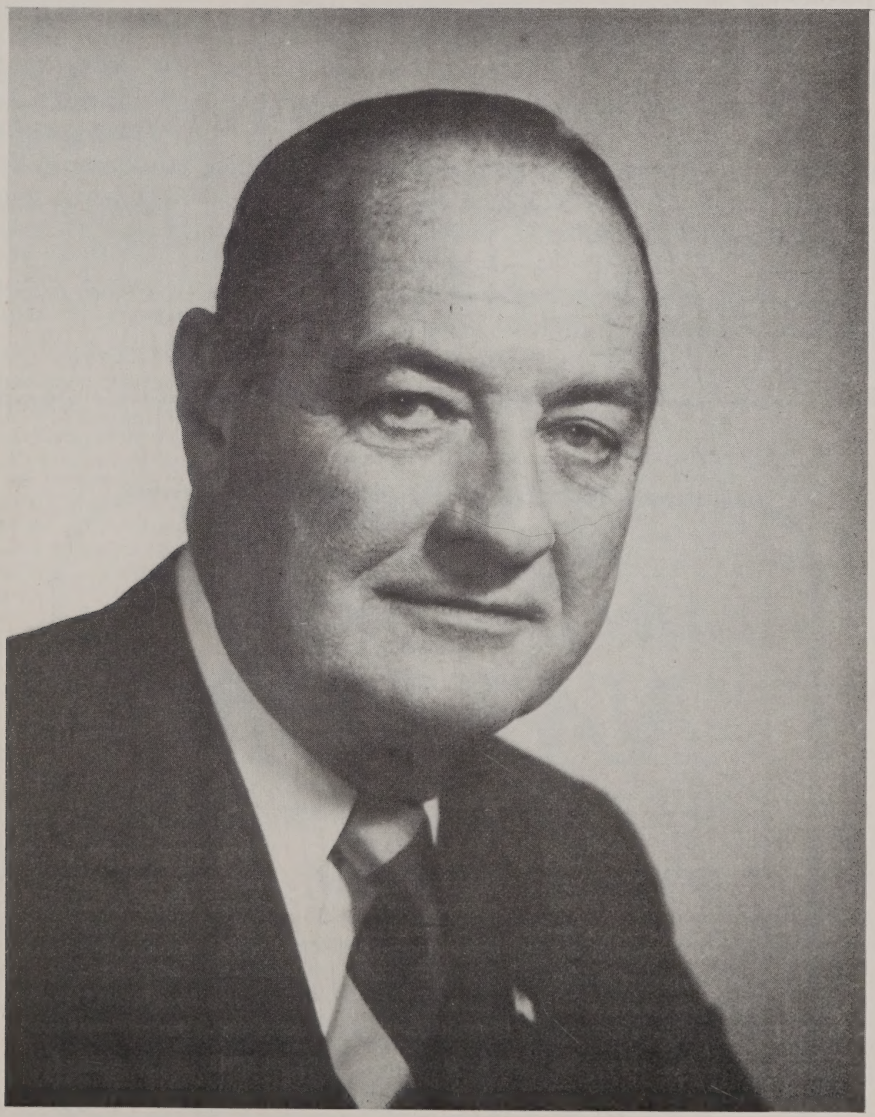
The Hampden Hippocrat

SEPTEMBER
1976



RICHARD E. PALMER, M.D.
AMA President 1976 – 1977

Tuesday, September 28, 1976
District Meeting of the
HAMPDEN DISTRICT MEDICAL SOCIETY

Business Meeting	**6:00 P.M.**
Social Hour	**7:00 P.M.**
Dinner	**7:30 P.M.**
Place	**Storrowton Tavern** **Stagecoach Barn** **West Springfield**
Speaker	Dr. Nason Burden, President, M.M.S.
Dinner	**Courtesy of HDMS**

If you must cancel your dinner reservation, call the office before noon on September 28, 1976.

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VOL. XXXII, NO. 7 SEPTEMBER 1976

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The official bulletin
for The Hampden District
of The Massachusetts
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William A. R. Chapin, M.D.

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THE HAMPDEN HIPPOCRAT is published monthly except for July and August.
The opinions expressed in this bulletin are those of the writers and do not reflect the official viewpoint of the Hampden District Medical Society unless so stated.
Communications pertaining to editorial content should be addressed to the Editor-in-Chief, W.E. Stevens, M.D., 24 Salem Road, Longmeadow, Mass. 01106
Business communications should be addressed to the Business Manager, J.B. Greenspan, M.D., 130 Maple Street, Springfield, Mass. 01105
Advertisements and Classified Ads should be directed to Mrs. Elsa Leahy, 3 Pearl Street, Westfield Mass. 01085, as Assistant to the Business Manager.
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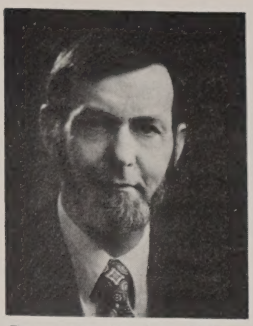

Bruce B. Stoler, M.D.

Your President's Page

"THE SUMMER LULL?"

During the "summer lull" your medical society has not been asleep, as the volume of material in this issue of the Hippocrat testifies.

Your society has been in frequent touch with our state legislators to express its opposition to the continuation of the 30 per cent reduction in Medicaid fees, mandated in the June 30 state budget. At this writing, the matter is still unresolved. Through the foresight of the Joint Legislative Committee on Health Care, state Senate bill S-1613 now provides for restoration of the fee cut and for up to an 8 per cent increase in these fees above the "yellow book" value presently in effect, but the Senate's bill is almost certain to be amended in the House. Dr. Dick Miller and his Legislative Committee are keeping on top of this bill.

During the summer Mrs. Purdy and Mrs. Weiss completed the apportioning of the membership to the councilors. The resultant lists will be published in the next issue of the Hippocrat. The councilors are charged with bringing the issues to the district membership and with soliciting their views for representation to the quarterly meeting of the Massachusetts Medical Society Council. In my view the accountability of each councilor to specific members as well as to the district as a whole is an important element of the responsibility of being a councilor.

Your society has been represented at two summer meetings of the PSRO, including one at which it met with Mr. Edward T. Choate, Director of the Medicaid Provider Review Unit. (This is the euphemism the state applies to the team charged with detecting cheating by physicians). From that meeting came an agreement that the Department of Public Welfare is willing to provide a signed patient release allowing the Medicaid reviewers access to the physician's records, for the purpose of the Medicaid Audit procedure **if the physician requests it,** when he is notified of a proposed DPW audit of his records. (Refer to recent HDMS newsletter.) This is an important protection for your Medicaid patients and yourself, ensuring that confidentiality of the medical record is not breached. I urge you to request such releases for each of your Medicaid patients, if audited! In this regard, HDMS has received the assurance of the MMS that it will be informed in advance of the DPW audit of any physicians in this district so that the advice and aid of the Society can be made available locally.

(OVER)

Your President-Elect, Doctor Verrilli, and I have met several times on the reorganization of the Peer Review Committee which is to concern itself with physician competence, the subject of my last President's Page, and in the organization of the new Members Committee which is to actively promote the case for joining organized medicine to the doctors of the District. As I brought out in my inaugural address, our strength lies in numbers, and the Members Committee will seek to increase not only the percentage of physicians practicing in Hampden as members of the District but also the percentage of AMA members amongst the members of the District.

When the concept of a Blue Shield "cooperating physician" was turned down by the state insurance commissioner recently, the Executive Committee of HDMS approved a resolution calling for legal action to force Blue Shield to pay the patient or the physician for services provided by a non-participating physician and forwarded it to the Massachusetts Medical Society for action by the Council in October. The resolution, which the Executive Committee approved in July, is reprinted elsewhere in this issue of the Hippocrat and will be available in limited quantities for distribution at the quarterly meeting of the District, September 28. Dr. Nason Burden, President of the Massachusetts Medical Society, will be our guest speaker. At this meeting Dr. James Allan, our Executive Councilor, and I feel certain that this resolution from Hampden will receive wide support from the Council. The impact of this change will be far-reaching indeed.

That's a quick summary of some of the action of your Society on your behalf during this "summer lull." And now we gird up for the "active season." See you at the District meeting!

Bruce B. Stoler, M.D.
President, HDMS

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Highlights of the Executive Committee Meeting

June 22, 1976

The Executive Committee met on Tuesday, June 22, 1976 in the Conference Room of the HDMS.

Present were Drs. Stoler, Verrilli, Moore, Sachsse, Cox, Magill, Bloom, Walthall, Trachtenberg, Lynn and Mrs. Purdy.

Absent were Drs. Teale, Stoddard and Smith.

The minutes of the May 19, 1976 meeting were read by Dr. Walthall and were approved by the committee as read.

CORRESPONDENCE

The Chairman of the Western Mass. Chapter of the Heart Association wrote asking for approval of a symposium where serum chloresterol tests will be done. The committee approved the program as outlined in her letter.

OLD BUSINESS

The committee discussed the Allen Photographers and the pictorial roster. Dr. Lynn reiterated that the roster should be like the red covered one reviewed and agreed upon originally. Members who have not been photographed will be listed at the end of the roster of photographed physicians.

Dr. Pace's answer to Dr. Stoler's letter about reports from the WMHPC was read. Dr. Pace suggested that information can be gleaned from copies of the minutes of the Board of Directors. He will notify HDMS of any special activities.

Dr. Warren Fisher of Hampshire District, had sent information about the HSA. Dr. Cox read a letter from Mr. Joseph Roche, Planning coordinator of the Western Mass. Health Planning Council requesting home physician representatives to attend certain sub-committees of the Southern Valley Health Planning Committee. Meetings held by these sub-committees are at hours difficult for M.D.'s to attend. After considerable discussion, it was agreed to have a representative of the society at these meetings, on a rotating basis, with initial assignments to be made from the membership of the Executive Committee. Dr. Stoler will answer the inquiry to Mr. Roche.

(OVER)

Ernest A. Byron, Jr.

SPRINGFIELD

Dr. Stanley Glasser had been invited to attend the meeting to discuss the pulmonary function screening clinic at Mercy Hospital; details of the clincial function tests were outlined. A letter will be sent to several HDMS physicians stating the Executive Committee's opinion, that this is a satisfactory gross screening test. Also, a letter will go to the Administrator of the Mercy Hospital, Sr. Laboure, requesting that results of tests be sent to the patient's physician directly instead of to the patient—if there is an attending physician. The Executive Committee further recommended that when the patient has no attending physician and the test is abnormal, he should be asked to call the medical society for information as to availabie doctors in pulmonary disease and not be referred back to the screening clinic.

Specialty listings to be used in the new yellow pages of the telephone directory were reviewed. The committee voted to employ a modification of the Milwaukee listing. Dr. Stoler will write to Mr. Scholfield of the telephone company to indicate the approved guidelines.

NEW BUSINESS

Dr. Zacarian, as Chairman of the Mediation Committee, indicated that a by-law change will be necessary to eliminate the Medical Charges part of the Peer Review committee.

Dr. Tillman has resigned as Chairman of the Member's Insurance Committee. Dr. Stoler has appointed Dr. Lorne Smith to replace Dr. Tillman as chairman.

MMS sent a list of five physicians who have been recently deprived of membership. Several of these physicians will be contacted by members of the Executive Committee and reinstatement will be suggested.

Dates for meetings in 1976-77 and speakers were discussed. Dr. Stoler and Mrs. Purdy will work out the details.

Mrs. Purdy reported difficulties with some secretaries in local offices on the telephone. Dr. Bloom and Dr. Verrilli suggested an article in the HH might best enlighten the membership to the problem.

Dr. Bloom and Mrs. Purdy attended the President's meeting in Boston. The confidentiality of Medicaid patients records was the topic of discussion.

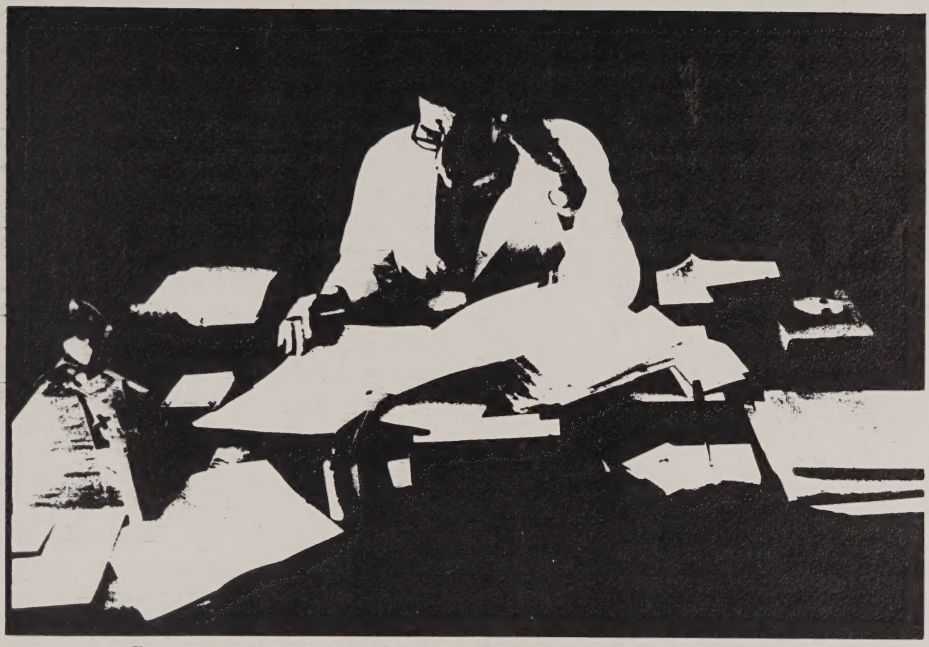
Blood pressure kits are being sold in drug stores and cannot be banned. A letter from Dr. Greenspan concerning the business side of the HH was read. The monthly mailing will be done from the HDMS office by Mrs. Elisa Lahey.

The Executive Committee approved the Editorial Board of the HH. Dr. W.E. Stevens will continue as Editor-in-Chief.

Dr. Zacarian wrote asking for permission to appear on an educational program on Channel 40. The committee approved this.

The meeting was adjourned at 10:45 p.m.

W.W. Walthall, M.D.
Assistant Secretary
H.D.M.S.



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RESOLUTION FROM THE EXECUTIVE COMMITTEE OF THE HAMPDEN DISTRICT MEDICAL SOCIETY

WHEREAS, in the year 1941, neither the government nor the insurance industry had a plan to solve the problem of medical expenses for the non-indigent, low-income patient, our predecessors responded to this social problem by causing an act to be enabled by the General Court creating the means to form a medical service corporation; and,

WHEREAS, this problem has since been undertaken by various state and federal programs; and,

WHEREAS, Blue Shield of Massachusetts, Inc., is the present and only medical service corporation in the Commonwealth, it is appropriate that the Council of the Massachusetts Medical Society consider the growth of this corporation into an immense and powerful insurance company which now indemnifies citizens regardless of their income status; and,

WHEREAS, virtually all physicians practicing in the Commonwealth are bound by a perpetuating contract with non-negotiable terms originally approved by our predecessors to encourage physicians to serve those unfortunate citizens of low income through the means of a medical service corporation; and,

WHEREAS, this contract and the statute upon which it stands is an abridgement of the freedom of an individual to choose his physician and the freedom of a non-participating physician to serve the public because of the denial of indemnification to the subscriber who chooses to be treated by a non-participating physician; and,

WHEREAS, it is the right of all citizens to bargain and make contacts freely and in good faith, our generation should not be forced to accept a contract with Blue Shield of Massachusetts, Inc., by the fear of economic deprivation and the knowledge that our patients will be denied indemnification from the corporation unless we sign the Participating Physicians' Agreement; statute upon which it stands is an abridgement of the freedom of an individual to choose his physician and the freedom of a non-participating physician to serve the public because of the denial of indemnification to the subscriber who chooses to be treated by a non-participating physician; and,

WHEREAS, it is the right of all citizens to bargain and make contracts freely and in good faith, our generation should not be forced to accept a contract with Blue Shield of Massachusetts, Inc., by the fear of economic deprivation and the knowlege that our patients will be denied indemnification from the corporation unless we sign the Participating Physicians' Agreement; and,

WHEREAS, the MMS Council has adopted a resolution from Suffolk District on February 9, 1972, clearly directing its Executive Committee (using the term "Voting Members of Blue Shield"):

"to proceed at once to restore a more cooperative balance between the Blue Shield Corporation and its participating physicians by whatever means may be required. In particular, the Voting Members are instructed to negotiate a new and more equitable participating physicians' agreement,

(NEXT PAGE)

and to arrange that Blue Shield shall pay subscribers for the services of non-participating physicians."; and,

WHEREAS, this mandate has not been rescinded and since the MMS has make many attempts to comply with the will of the Council, including a petition to the General Court; and,

WHEREAS, by act of the legislature effective July 1, 1976, Section 7 of Chapter 176E of the General Laws, appearing in Chapter 714 of the Acts of 1962, has been amended to provide that a dental service corporation in Massachusetts shall pay subscribers for the services of both participating and non-participating dentists; and,

WHEREAS, it is now appropriate to take final action to eliminate this injustice to physicians and their patients; NOW THEREFORE:

BE IT RESOLVED, that the Massachusetts Medical Society directs its legal counsel to commence forthwith a challenge to the legality and constitutionality of Chapter 176B, Section 7, of the General Laws (Acts of 1941), denying indemnification to a subscriber of a medical service corporation when ministered to by a non-participating physician who practices within the Commonwealth; and,

BE IT FURTHER RESOLVED, that said legal counsel shall commence forthwith an action in the Courts to challenge the equity of the participating Physicians' Agreement of Blue Shield of Massachusetts, Inc.; and,

FURTHER, BE IT RESOLVED, that the officers are directed to continue their efforts to correct this injustice pending final adjudication; and,

FINALLY, BE IT RESOLVED, that a special assessment of the Fellows in a sum not to exceed twenty-five dollars ($25.00) be instituted, as necessary, to fulfill the mandates of these resolves.

APPROVED: July 28, 1976

Signed

Bruce B. Stoler, M.D.
Chairman, Executive Committee
Hampden District Medical Society

ATTEST:

Philip B. Stoddard, M.D.
Secretary, Hampden District Medical Society

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Report of the HDMS Golf Tournament

The HDMS Golf Tournament was held on Wednesday, August 4th at the Twin Hills Country Club. It was a beautiful day and the golf course was excellent. Nineteen physicians participated and enjoyed themselves, although the play was slow. An excellent steak dinner was served to thirteen.

The chairmanship has been passed to Kenneth McEwen, M.D. who has helped me for several years and I hope greater interest can be stimulated for future tournaments.

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Runner up	83
1st low net	71
2nd low net	73

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HAMPDEN DISTRICT MEDICAL SOCIETY MEETINGS AND OTHERS

District Meetings
Tuesday, September 28, 1976
Tuesday, November 23, 1976, with Academy of Medicine and Auxiliary
Tuesday, February 1, 1977

(Places to be announced)

Censor Meetings
Thursday, December 2, 1976
Thursday, May 5, 1977

Pre-Council Meetings
Thursday, September 9, 1976
Thursday, January 6, 1977
Thursday, April 14, 1977

State Executive Committee Meetings
Wednesday, September 15, 1976
Wednesday, January 12, 1977
Wednesday, April 20, 1977
Wednesday, September 14, 1977

American Medical Association Meetings
Clinical, Philadelphia, November 28-December 1, 1976
Interim, Chicago, December 4-7, 1977
Winter Scientific, Miami Beach, December 10-13, 1977

Annual Meetings, 1977, San Francisco, June 18-23, 1977; 1978, St. Louis, June 17-22, 1978

Executive Committee Meetings
September 21, 1976,
October 19, 1976,
November 16, 1976
December 21, 1976
January 18, 1977

February 15, 1977
March 15, 1977
April 19, 1977
May 17, 1977
June 14, 1977

State Council Meetings
Wednesday, October 13, 1976
Wednesday, February 9, 1977
Wednesday, May 18, 1977
Wednesday, October 12, 1977 (to be held in Springfield)

State Annual Meeting
May 24, 25, 1977

NOTICE:

Please note insert — these are proposed Bylaw changes to be considered at the September 28th meeting of the District.

1) Reorganization of Peer Review committee.
2) Changes in composition of Mediation committee

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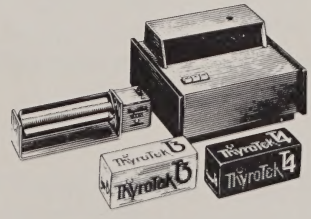

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Editors' Standing Assignments

J. Zadworny, services available to HDMS physicians; the Department of Public Health; advocations and achievements of HDMS physicians

S. Zacarian, the Mass. Medical Society; National Societies; the Arts and HDMS physicians

A. Sheffield, free lance and for special assignment; personal achievements of HDMS physicians and spouses

H. Simpson, Poet's Corner, Hospital Administration serial

A. Peck, Medical Staff Facts and Problems, Censors Committee reports, Springfield Academy of Medicine

C. Janovsky, Foundations, PSRO, HMO; Medico-legal Affairs

J. Hafer, New Members, Deaths; Calendar of Events; Medico-political affairs

B. Bloom, Socio-economic affairs, Public Relations; Third party payors

R. Berrien (guest), the female view of medicine; free lance for special assignment

P. Stoddard, HDMS material, synopsis of meetings and highlights of Executive Committee; May issue

W. Stevens, Auxiliary to the HDMS

Readers:

If you have material for publication in the above categories, submit it to the appropriate editor — as listed above.

Themes for Forthcoming '76-'77 Issues of The Hampden Hippocrat

September 1976, AMA issue and Summer wrapup

October 1976, Auxiliary to the HDMS, Women in HDMS Medicine

November 1976, Physician Assistants and Nurse Practitioners

December 1976, Holiday Issue Ethics and Discipline, New Members

January 1977, The Blues and Third Party Payors

February 1977, Foundations, PSRO and HMO and the HDMS

March 1977, Legislative Issue and Public Relations, Drug Pricing

April 1977, Annual Reports, President's Swan Song

May 1977, HDMS change of Administration, New President's Message

June/July 1977, MMS Issue, New Members

Readers:

Contributions to the Hampden Hippocrat, either fitting into themes or on seperate issue, are always solicited. If you wish a subject or item included contact an editor.

Poet's Corner

Last January, in its Readers Talk Back column, **The Springfield Union,** hiding behind the **nom de plume** of Ben. Arnold, quietly noted that the American Revolution had passed us by in this area except for the excessively celebrated expedition of Col. Knox. It went thissaway.

We gathered at the lakeside with our leader Col. Knox'n
We had some spavined horses and we had some yokes of oxen,
We knew the trail ahead of us was perilous and long,
We hadn't bathed for many weeks, but we were thirty strong.
We left Ticonderoga with our guns and cannon balls.
It was much like Montezuma but there wasn't any halls.
In fact there wasn't anything but slips and slides and lurches
Except the chicken pie routine in all the schools and churches.
At times we wondered how on ice and snow we'd ever make it,
And wished we had a tractor and a truck so we could take it.
Our leader spent a lot of time in writing in his journal
Till finally we said to him, "We're very worried, Colonel,
Suppose we get to Albany and spend our whole allowance?"
"We'll send the stuff by first class mail at thirteen cents an owance."
Our officers reminded us that we must do our duty,
And Col. Knox went off the trail to find himself a cutie.
We couldn't help admire him. The rest of us were weary.
When he returned, our greeting was, "We have a little query.
A date in all this wilderness? How could you be so sure?"
He casually replied to us, "Oh all the horse-men knew 'er."
We said, "Oh damn," in Wilbraham, "these roads are rough and hilly,
And Spec Pond as a camping site is just a trifle chilly."
"Is Worcester next?" we hopefully inquired from a farmer.
Disdainfully he answered us, "Hell no, it's only Parmer."
A message came from Washington that made the outfit wince,
So like the words from Washington we've suffered ever since.
"Don't put the cannon in the creek, the horse before the cart,
And also please remember if you don't get out the lead you'll
Never get to Dorchester for weeks behind the schedule.
The troops are getting nervous and the town is getting skittish.
You're going to have to hurry if you hope to scare the British.
Don't stop to do your laundry and forget the soap and starch,
For General Howe evacuates the seventeenth of March."

HNS.

Gas pains . . . .
USE
MYLICON — 80

THE PAGE OF THE AUXILIARY TO THE HAMPDEN DISTRICT MEDICAL SOCIETY

FALL LUNCHEON

Circle September 28th on your calendar for a very special luncheon meeting at the Yankee Pedlar Opera House. On that day, Mrs. Gardner (Elizabeth), National President of the American Medical Society Auxiliary, will be our honored guest and speaker. We are very fortunate to have Mrs. Gardner here in western Massachusetts and your officers and committee members hope everyone will make a special effort to come. Charter members will be honored at this time as well. If you're going invite a fellow auxiliarian along.

FOOTBALL ALERT

It's definite now! Our first Football Frolic will take place Sunday, October third, at Shaeffer Stadium—when the New England Patriots play that team from Oakland, Ca. A bus has been chartered and it will leave The Longmeadow Community House at 9:30 A.M. Lunch and trimmings will be included in the arrangement's price. If you and/or your spouse wish to be part of the Frolic, your prepaid reservations must be in the hands of

Mrs. Paul Friedman (Janie)
133 Wild Grove Land Phone No. 567-8031
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No later than Saturday, September twenty-fifth. Reservations are limited to 40 persons and they are $22.00 per person— First calls to Janie means the first served and bussed.

GENERAL NEWS

The Board has been quite busy all Summer, with projects and plans for a worthwhile year. The Welcome Wagon group, headed by Mrs. Robert Bye (Cynthia), has made several visits to new medical families. If you become aware of any new physician families moving into Hampden District please call Cynthia at 567-8562, so that she and her group may plan a visit and take the newly arrivees the Auxiliary's Welcome Kit.

The Auxiliary has three new members: We all welcome their membership.

Mrs. Marvin Hoovis (Beverly)

Mrs. Kollegal S. Murthy (Helene)

Mrs. Manuel Santiago (Leticia)

Mrs. Robert Nennenger [Patricia]

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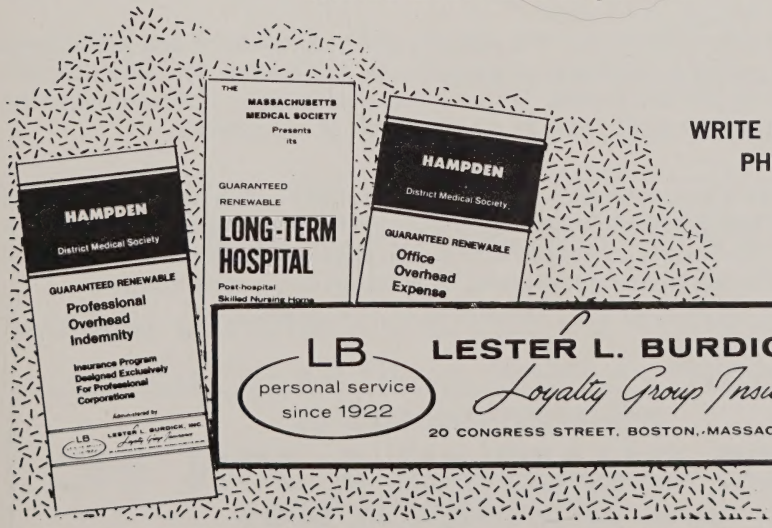

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A Message from Richard E. Palmer, M.D.
The President, American Medical Association to All Branches of Organized Medicine

In my Inaugural at Dallas, I said that during my term as president of the AMA I would press for unified membership throughout our federation. For each and everyone of us, it's the only way to go.

Unity will help each of us cope with problems that otherwise would be overwhelming, including the threats from a non-stop torrent of federal legislation and regulation. The government is trying to repress us not by any single blow of the sword (as happened in Britain) but by a kind of Chinese water torture.

Two of the latest thuds of heavy water are:

(1) H.R. 14319, which would completely revise the present Clinical Laboratory Improvement Act, and

(2) Senator Herman E. Talmadge's bill (S. 3205) aimed at "reform" of Medicare-Medicaid administration and reimbursement.

Unrelated as these two bills may appear on the surface, they have a grim common thrust. Both would impose some type of standardized fees on our profession.

The laboratory measure, furthermore, would force many a physician to close the lab in his office and would have a disturbing or numbing effect on lab work in general.

It would exempt the doctor who actually performs all tests and procedures in connection with the treatment of his patients, but present law also exempts a lab operated by his employees. To get either exempted or licensed under the proposed revision, he would have to meet a batch of regulations.

A physician's percentage-of-receipts arrangement with a hospital to which he furnishes lab services would be ineligible for Medicare-Medicaid reimbursement. If the idea is to whittle him down to being a salaried employee of the hospital, his service incentive could be whittled down accordingly.

(NEXT PAGE)

58th ANNIVERSARY YEAR

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The bill also has some gimmickry for attaining a uniformity of lab-service fees between government-subsidized and non-subsidized patients. Lack of uniformity would be grounds for lab-license revocation. What precedent could be more sinister than letting the HEW Secretary be both a fee comptroller and a license revoker?

Under the Talmadge measure, Medicaid fees paid physicians for out-patient care would be not less than 80 per cent of "reasonable" charges under Medicare. This may sound appealing, since Medicaid fees in some states presently are as little as 50 per cent of the Medicare figure.

But what's fair about even the Medicare figure? Medicare and Medicaid were designed to put their beneficiaries in the mainstream of medical care. Physicians generally strive to provide one high standard of care for all patients. How can the government now condone payment differentials, yet expect beneficiary satisfaction? Isn't it actually seeking a copout on its promises to the elderly and the poor?

Also under the Talmadge bill, there would be two assistant secretaries of health handling health programs covered by the Social Security Act. The new one would head a Health Care Financing Administration. His hierarchy would include an Inspector General with authority to review and audit those programs..

Such extra bureaucracy and red tape would be expensive, and the expense could be turned into a further financial onus on health-care providers. Moreover, as HEW Secretary F. David Mathews told the Senate Finance Committee, the added officialdom would not necessarily achieve efficiency.

The AMA is staunchly fighting the objectionable features in the Talmadge and lab bills. It's the kind of fight that only the AMA can wage. It's one of the many kinds of battle that demand, and justify, unity throughout our ranks—and unified membership throughout our federation.

Remember: Washington measures organized medicine's strength not only by its resoluteness but by its numbers. And those numbers mean each and every one of us.

Richard E. Palmer, M.D.

President American Medical Association

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PERSPECTIVES ON HEALTH CARE IN MASSACHUSETTS

Jonathan E. Fielding, M.D., Commissioner
Department of Public Health
The Commonwealth of Massachusetts

In meetings throughout the state, this past year, I have stressed that the responsibilities of the Department of Public Health to guard the health of the people of the Commonwealth fall into three major categories: **health services, health protection** and **health regulation.** Although the regulatory role of the Department is required by both state and federal government, I view regulation as only one aspect of public health activities. Despite the trend toward more regulation, I believe there is too much regulation in many areas, especially with respect to standards for nursing homes and hospitals. The Department has been working to bring order to they myriad, often contradictory, regulations that have proliferated over the years. Suggestions to the federal government led to agreement on the interpretation of the life-safety code that has saved the taxpayers of Massachusetts $100 million.

At the same time, we have been working with physicians and other health professionals to find ways of improving services and of reducing health care costs while maintaining a high quality of care. Some of the areas discussed have been: the possibility of more surgery performed on an outpatient service, increased availability of home care, better insurance coverage for ambulatory care, and the availability of services for children and patients of our human service agencies.

Meanwhile, the Department has, within the confines of a curtailed budget, continued the traditional services of public health—family and children's services, communicable and venereal disease control, TB control, alcoholism services, food and drug program, hospital and laboratory services.

The Department has also been able to introduce new, or to expand existing, programs. The Metabolic Disorders Screening Program, the first legally mandated state program in the country, now tests for 31 inborn errors of metabolish. The most recent test, added to the program on January 1, 1976, screens all babies in Massachusetts for hypothyroidism. An important outgrowth of the testing program is the accumulation of information that now allows researchers in the Department to separate those chemical abnormalities that do cause disease or disability from those that do not.

(NEXT PAGE)

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The Metabolic Disorders Laboratory has, since early January 1976, been testing for the newly established New England Regional Metabolic Disorders Screening Program. Funded by a federal grant, the program screens for a limited number of metabolic disorders for Maine, Rhode Island and Connecticut. The aim of the program is to include all of the New England States in a regional system that will prove more cost-effective than individually operated state programs.

Two bills introduced by the Department in 1975 and signed into law in the closing days of the General Assembly should also be of special interest to physicians. The first law provides for a system of licensure for the many independent clinical laboratories that have been operating without any controls in Massachusetts. By removing the danger of unqualified groups or individuals from setting up sub-standard laboratories, the law will result in improved quality of services offered by private laboratories.

The second statute, by allowing the Department greater flexibility in the use of its hospitals, permits treatment of mentally ill and mentally retarded patients in public health facilities. This statutory change made possible the complete consolidation of the Gardner State Hospital with Rutland Heights Hospital, effective July 1, 1976; and treatment at the Lemuel Shattuck Hospital of patients from both the Department of Mental Health and the Department of Correction. In addition, the Department has been involved in planning with the two departments and the University of Massachusetts Medical School in Worcester to build a system of public health better integrated and coordinated than in the past.

The Department has also been considering what its role should be in the provision of medical services through its seven institutions. Concomitantly, the hospitals have continued to work closely with regional planning and community groups, and with other hospitals, to develop programs for needed services that are not provided by other hospitals, voluntary or private, or by other health agencies.

As the Department carries out its daily activities, it must be concerned with some of the broader issues that loom ahead. Fundamental to any discussion of perspectives on health care is the question of cost containment and a more rational allocation of resources in the nation and in the state. To plan for the future, the Department and other concerned agencies worked first to identify health costs. At the request of the Governor, the Health Planning and Policy Committee of the Commonwealth prepared a "White Paper on Health Care Expenditures in Massachusetts," which documents the dramatic rise in health care costs and expenditures. In the next few months, the Committee will reexamine the proposals put forth in the White Paper and develop plans for their implementation.

(OVER)

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Within the framework of the present allocation of funds, much more attention must be paid to the prevention of disease and accidents. What is needed is an extraordinary campaign of education on those diseases and social habits that are imperiling the lives of tens of thousands of Americans—excessive smoking and drinking, poor eating habits, driving unsafe cars at unrealistically high speed limits, and drug abuse. In this process of health education, the practicing physician has a unique role. He is in an advantageous position to teach patients to be responsible for their own health and for the health of their children.

In the period ahead, providers of health care and the public will be looking more closely not only at the costs of care but also at the quality of care. To this end, the Commonwealth has added to the responsibilities of the newly enlarged Board of Registration and Discipline in Medicine. A parallel effort to control the quality of care has been undertaken by the medical profession itself. The Massachusetts Medical Society is on the process of organizing its Audit Committee, whose function will be to plan and to aid in a system of review of professional competence of its members.

The activities of these groups, combined with the work of utilization review committees of hospitals and other health facilities, can help ensure a high quality of care. The Determination of Need Program of the Department of Public Health is another mechanism being effectively used to guarantee high quality of care and to curtail cost increases by eliminating the wasteful duplication of resources and services.

An additional word or two about planning: Many individuals have, in the past, expressed the opinion that some of the budget cuts in individual state programs could have been avoided had there been a coordinated approach to planning, both of programs and of facilities. In Massachusetts, health policy has been fragmented and unstructured through several secretariats; and 26 health plans have been operating in the state—all unrelated and all federally funded. This situation will change under provisions of the National Health Planning and Resources Development Act (P.L. 93-641). Building on the experiences of earlier programs—Hill-Burton (1945), Comprehensive Health Planning Act of 1966, and the Regional Medical Program of 1965—P.L. 93-641 offers an additional instrument for the coordination and development of necessary health resources while preventing costly surpluses.

(NEXT PAGE)

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Physicians can play a special role in the implementation of the planning act, which requires the Health Systems Agencies (HSAs) to enter into written agreement with Professional Standards Review Organizations (PSROs) in the health service areas to coordinate the activities of both groups. Exchange of data and the provision of technical assistance will result from such a coordinated approach. Perhaps even more important is the provision in the law that permits the PSROs to review, and to comment on, the Health System Plan and the Annual Implementation Plan that each area will prepare. The Department has taken a strong, progressive attitude toward the law, and is giving it full support.

Never before has the need for effective health planning been more urgent. New developments in the health field, proposals for a national health insurance system, the uneven distribution of health manpower require the cooperation of all health professionals if solutions to common problems are to be found. The days are long gone when one coud talk about the public versus the private sector in the health field. The problems are so complicated today that no one group or agency alone can solve them—not the private practitioners, nore the carriers, neither the state nor federal government, nor the hospitals. The times require full public and private cooperation to begin to tackle these issues. In this endeavor, the members of the Hampden District Medical Society will, I am certain, be effective participants.

Jonathan E. Fielding, M.D.

Commissioner-Dept. of Public Health

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NATIONAL HEALTH MANPOWER STRATEGY

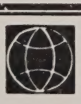
by Senator Edward M. Kennedy

The critical need for physicians, dentists and other health professionals has been a major national concern for many decades. Since the passage of the Health Professions Educational Assistance Act in 1963, the Federal government has taken an increasingly active role in assuring the nation of an adequate supply of health manpower. Federal support initially took the form of educational grants to medical, dental and other health professions schools, construction assistance for educational facilities, and loans and scholarships for students. The latest amendments to this legislation were passed by Congress as part of the Comprehensive Health Manpower Training Act of 1971. This Act was largely shaped by the 1970 report of the Carnegie Commission, Higher Education and the Nation's Health, which defined and documented the extent of shortages of health manpower. While the report addressed the issue of geographic maldistribution and noted that merely increasing the supply of physicians would not assure access to health care, the statement of the Assistant Secretary of Health, Dr. Roger Egeberg, that the nation needed 50,000 more physicians, several hundred thousand additional nurses and nearly 150,000 more technicians become paramount. As a result, the 1971 Act focused primarily on increasing the output of professional health manpower and stabilizing the finances of health sciences educational centers.

The effect of these federal programs has been to markedly increase the supply of health manpower. By providing financial support for higher enrollment, first year medical school positions increased from 8,759 positions in 1965 to 13,790 in 1973, or fifty-seven per cent. Based on current enrollment, medical graduates in 1980 should exceed 16,000 as compared with about 9,000 in 1971. This output compares favorably with most western nations, such as Great Britain, which has set an annual goal of 4,000 medical graduates for a population that is approximately one-quarter of the United States. Similarly, American dental students increased more than thirty-five per cent between 1960 and 1973 and the number of practicing dentists grew 9.5 per cent between 1968 and 1974.

Unfortunately, in spite of the improved supply of health manpower, the serious problems of geographic and specialty maldistribtuion have grown worse. The disparity between urban and rural manpower supply is growing worse and the number of primary care physicians continues to decline. We have learned two lessons. First, increased output of doctors alone will not improve geographic maldistribution or access to health care for the average American. Second, conventional or market solutions to improve distribution have not worked.

(NEXT PAGE)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In 1966, primary care physicians accounted for 46 per cent of all active physicians but this percentage fell to 43.6 per cent by 1974. Family physicians accounted for only 1.4 per cent of all active doctors in 1972 and over eighty per cent of all active physicians are now in specialty practice. Many sections of the country have ample physician manpower and good access to medical care while other areas still have no doctors. In 1970 more than 130 counties had no physicians and more than one-half of the counties in 25 states had fewer physicians on a per capita basis in 1970 than in 1960. Regardless of how you view it, the population per physician ratio in Massachusetts (476:1) is disproportionate to the greater than 1000:1 ratios that exist in eleven states. Statistics show that the states with the best supply of physician manpower are increasing their ratios faster than doctor-poor states. Moreover, within states, the distribution between urban and rural areas is even more skewed. Rural areas contain 27 per cent of the population, but only 14 per cent of the active physicians and physicians practicing in rural areas tend to be significantly older than their average city counterparts. Even within urban centers, the decreasing inner-city physician ratios are masked by the proportion of their colleagues in the suburbs.

The Senate-approved health manpower bill which was developed by my Health Subcommittee, is designed to alleviate the basic problems of geographic and specialty maldistribution. With respect to improved geographic availability, the bill proposes to expand the existing National Health Service Corps Scholarship program both in terms of how Corps physicians may be asigned and how many scholarships are available to health professions students. While still emphasizing the health manpower needs in rural areas, the Corps program is being redirected from a strictly rural perspective to include underserved areas in inner cities and institutions such as mental hospitals and prisons which traditionally have had difficulty attracting skilled medical manpower.

The scholarship program is entirely voluntary. In return for receiving a scholarship, which will pay a stipend, tuition and other educational expenses, each student will agree to serve one year in an underserved area for each year he or she receives scholarship support. The graduate physician may choose to perform this service either as a member of the National Health Service Corps or as a private practitioner.

The problem of specialty maldistribution of doctors was dealt with in the Committee-passed bill by a certification program which would establish the total number and type of graduate training positions and by a requirement that a minimum percentage of graduate positions be in a primary care specialty. The bill was amended on the Senate floor, however, to require only that one half of the residency positions affiliated with medical schools be in primary care (family practice, internal medicine, pediatrics and obstetrics and gynecology). I believe that this compromise establishes an appropriate direction for graduate medical training without interfering unduly with the medical education process.

A third health manpower problem addressed by the Senate-passed bill is the Nation's excessive reliance on foreign-trained medical graduates. In 1959, foreign medical graduates comprised less than six per cent of all physicians in the nation but in 1974 more than one-fifth, or 76,504 licensed doctors were graduates of foreign medical colleges. More than one-third of all physicians currently in graduate training programs are foreign graduates and more than 50 per cent of physicians newly licensed to practice are foreign-trained.

(OVER)

While the numbers are alarming in themselves, I am particularly concerned with the implications for the quality of care provided by some foreign graduates and the foreign policy issue created by encouraging the emigration of scarce medical resources from nations which desperately need many more competent physicians.

Foreign medical graduates have not attended an accredited United States medical school. They have not been supervised in what is regarded as the highest quality medical education system in the world nor are they subject to the rigorous admission, preclinical and clinical training process required for American graduates. Furthermore, I am not persuaded that a written examination can adequately substitute for the eight years of intensely keen competition and socialization that prepare U.S. students.

The Senate-passed bill amends the Immigration and Naturalization Act to assure that foreign medical graduates meet quality requirements roughly equal to their American counterparts. Under the exchange visitor program, applicants must have passed Parts I and II of the National Board of Medical Examiners examination or an equivalent test and participate in a program sponsored by a U.S. school of medicine. These applicants must enter a training program that provides skills required in their home country and agree to return to their country upon completion of their training. Students in this program may remain in the U.S. for no more than two years, although an additional year may be granted on the express request of their government for a third training year in a particularly needed specialty.

The bill also modifies certain existing immigration preferences for physicians. While physicians of truly exceptional scientific ability will still be able to enter the United States as research scientists, physicians who simply want to live and practice in the U.S. must meet the same requirements for immigration as any foreign national.

The Senate Health Subcommittee highlighted two other health manpower issues. First, the inconsistent requirements for licensure among states is felt to unreasonably restrict physician mobility between different areas of the country. It may contribute to scarcity in some areas and excess supply in others. More importantly, present licensing systems are not responsive to their primary purpose of insuring continued competency. Little effort is made to identify individuals with substandard skills and insure that they improve their performance or leave practice.

(NEXT PAGE)

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The Senate Bill includes provision to develop and establish model standards for state licensure for physicians and dentists. It is intended that these standards be developed with the full participation and support of appropriate professional organizations and not pre-empt any state laws regarding medical or dental licensure. I believe that the medical profession itself must generate increased interest and momentum to self-regulate and accept full responsibility for assuring the continued competency of practitioners to the American people.

The last major provision of the Senate bill, occupational health, is a relatively new and seemingly undramatic issue. In the last few years, however, the Committee has become increasingly concerned with the incidence of occupational disease and its impact on the Nation's work force and economy. The National health survey has estimated that the average worker experiences six days of absence and more than 16 days of restricted activity each year due to some type of job-related disability. At least 390,000 new cases of occupational-related disablement or death occur annually. Diseases range from overt, classic cases of lead or mercury poisoning to the delayed effects of noise exposure that cause hearing loss. Man-made dusts have been found to cause fibrosis of the lungs while exposure to certain chemicals in the work environment may induce cancer.

I believe that occupational health and its implications for the American worker is a largely unrecognized health problem that merits high priority. One of the key new provisions in the Senate manpower bill authorizes the expenditure of federal funds to establish and operate occupational health training and education centers. Grants will be awarded to encourage cooperative training in occupational health for doctors, nurses and industrial hygienists among schools of medicine, public health and allied departments and schools.

The health professions schools have been increasingly recognized as National resources under health professions assistance legislation. As the public support has grown, the expectations of the American people have been increased for reasonable access to high quality health care. I believe that the Senate bill established necessary priorities for the future. I believe that when the manpower legislation becomes law later this year it will be embraced by practitioners and medical educators alike and that working together, we can build a health education and delivery system that is truly responsive to the needs of the American people.

Edward M. Kennedy

U.S. Senator-Massachusetts

Editor's Note: Senator Kennedy has stated his views on national health manpower strategy. You are invited to state yours or to indicate your approval or disapproval in a letter to the Editor. What Senator Kennedy is trying to do is help our patients and we physicians. He needs your input to do his job properly.

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A BECENTENNIAL PLEA
by Alfred J. Luoni, A.I.A.

Massachusetts Governor Michael Dukakis was reportedly miffed by recent newspaper reports that business, located within the State, is being taxed and regulated to the point that many have no alternate for survival but to relocate. As a result, unemployment levels have been and continue to be among the highest in the nation, while our social welfare system plus the bureaucracy which administers it, expands by leaps and bounds.

There is only one sensible answer to our State's present social and financial chaos—**JOBS.** Jobs for all those who want to work. Nevertheless, within the past three years, the Massachusetts Department of Public Health (Certificate of Need) has said **no,** or delayed approval of approximately 680 million dollars in hospital construction urgently needed to replace old and antiquated facilities scattered throughout the Commonwealth.

The State's argument is based on the contention that our existing medical facilities, many of which were constructed over a quarter of a century ago, are more than adequate to accommodate those of us afflicted with sickness, plus cost less to operate than a new structure.

One has to look no further than their local community hospital where they will find a great number of patients housed or being treated in structures that have **NO air conditioning system[s], NO smoke or fire protection system, inadequate heating and ventilating systems, inadequate lighting, plus spaces that appear cold, cramped, and sterile.** As a matter of fact, it's a rarity to find a hospital structure within the State that complies with regulations pertaining to the handicapped, plus earthquake (seismic) design.

A typical application for a **Certificate of Need** usually entails extensive/costly research, planning, and counsel on the part of the respective hospital/institution without any assurance from the State that a certificate will be granted. A normal review period can run anywhere from six to twenty-four months, which unto itself can add 10 per cent to a construction project's overall cost.

Since Massachusetts is the State **"WHERE IT ALL HAPPENED,"** why not do now for the sick and aged what our forefathers did for us.

During the remainder of 1976, please CALL/WRITE/TELEGRAM your local State Representatives with an urgent appeal to relax or abolish State Department of Public Health's prepequisite for a **Certificate of Need.**

(NEXT PAGE)

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If this appeal process succeeds, approximately one-half billion dollars in hospital construction will get underway immediately, 30,000 jobs will be created, a new spirit of cooperation between state and business will be reborn; plus, we the people can be assured that Massachusetts will have the best available hospital facilities to complement the best medical staff, which we have.

"I find the great thing in this world is not so much where we stand, as in what direction we are moving...we must sail sometimes with the wind and sometimes against it—but we must sail, and not drift, nor lie at anchor." _____Holmes

_____Alfred J. Luoni, A.I.A.
Chestnut Hill, Mass. 02167

ED'S. NOTE: Another view of a Massachusetts problem. Part of a master plan to **disorganize** medicine??

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What bureaucrat bewails his doom?
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"All I had I gladly gave."
Nothing more his soul to save
Of old Doc. Robbin.

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EDITORIAL: COMMENTS OF THE CONTENTS

As our President states the summer is over and where was the supposed lull? The Hampden District continued to function and conduct the essential business of organized medicine; committees met—a resolution was approved and found herein, see page 10 & 11. Patients developed the same number of predictable illnesses and accidents (except for Philadelphia and the Pennsylvania legionaires). Dr. Stoler's idea to make a district councilor responsible for and responsive to a fixed number of society members reveals his republican thinking (please note the small "r")and it may well bide for a more effective involvement of the district members and their elected councilors. If it works well I'm sure the idea will spread to other district societies.

The next District meeting will be at Storrowton Tavern, Tuesday, September 28, 1976. The Auxiliary to the Hampden District Medical Society (please note the change in name) under the hand of Mrs. William Yorcyk (Carrol) will be hosting Mrs. Norman Gardner (Elizabeth), the President of the Auxiliary to the AMA and also is planning a bus run to watch the Patriots beat or be beaten by the Oakland Raiders.

The usual theme for September is the AMA and Dr. Richard Palmer has a message for you all. He reiterates what has been my editorial policy; i.e. the greater the numbers of physicians in organized medicine at all three levels, the greater our strength and the better is our clout. Clout, we must have to turn back or aside bills such as he mentions. I believe American Medicine has lost the initiative and no longer can propose and mount legislation which are in its own best interests (as some lobby groups can still do). We all agree that some form of "nationalized direction of health care and health delivery" is being forged in Congress and by both presidential candidates. American Medicine thru its organizations must assure the patient/citizens that what they get is what they can afford, is what can be delivered by the existing health care team and that the high standards of care available to most will not succumb to the mediocrity inherent in a "social solution" of each individual getting the same as his or her fellow roommate. The cost of membership in the MMS and/or the AMA will never match the loss of private practice and decision making inherent in a **National Health Service.**

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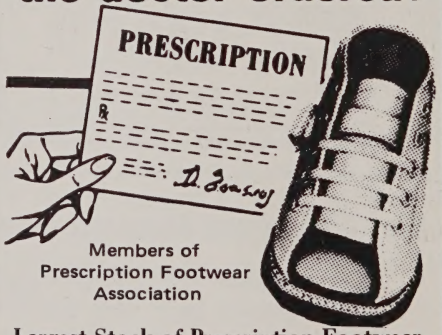

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The Hampden Hippocrat, through the efforts of Viv Purdy, is pleased to publish two manuscripts from non-district men who are most influential in Commonwealth and National Health Care & Delivery circles; Commissioner Fielding of the Department of Public Health and U.S. Senator Kennedy. Doctor Fielding indicates that the Department of Public Health divides its activities with respect to guarding the public's health into three areas; health services, health protection and health regulation. In spite of budget difficulties each area needs to expand, for to the Editor, the public's health is a new frontier of American Medicine. It must convince the public—our patients, that what they are doing to themselves to cause dyshealth must stop. Just as we are able to control many of the diseases that formerly killed, crippled or incapacitated our fore fathers and mothers. The Editor disagrees with Dr. Fielding wherein he states that "...the practicing physician has a unique role. He is in an advantageous position to teach patients to be responsible for their own health and for the health of their children." Personal experience in general practice showed that once the child ceased to come to the family doctor or pediatrician the educational role also ceased. Smoking, drinking, drug abuse and poor health habits usually start in the teens and except for trauma or overwhelming infection—the teenager and the young adult do not come to the physician. One does not talk about stopping smoking to the teenager who has just run into a tree, with his car and after a few beers, at 85 MPH. When the middled aged adult begins to return to the physicians office, now the 30 years of personal neglect or improper practices have already taken their toll—the education now comes too late. Education about health and preventive medicine must get to the public before and not after the fact. Here the nation's public health officials can and should step forward and educate towards better health; viz. the warning on the cigarette package is not enough. An expanded role of public health education using all the media and the public's schools will do more for this Nation's good health, than all the legislation to regulate, than all the services to provide after-the-disease care. Health protection by the state and federal government should mean stop the dyshealth or disease before it starts. As have many Massachusetts physicians, the Editor has had business with the department of Public Health and he can appreciate the Commissioner's task; it is big, difficult and bureaucratic. From the editor's position the department should be involved in three areas of need; a) input into and from the Department of Welfare to better coordinate Health and Welfare problem of an individual patient/citizen, b) the state should resume its role of providing health care facilities for those who can no longer do so for themselves, and c) stimulate the growth of facilities whereby those no longer in need of "acute bedcare" can be readily

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transferred and the drain on the insurance dollar can be lessened. Regulation and control at the state level is essential and vital—but at times common sense of the commonweal should prevail. The Editorial Board thanks Commissioner Fielding for his manuscript and the revelations therein. It would be pleased to publish pertinent and timely data, information and opinions of his department from time to time for the benefit of the Hampden District physicians.

Senator Edward M. Kennedy has provided the Hippocrat's readers with his ideas, opinions and actions in his manuscript entitled "The National Health Manpower Strategy". We all are aware of Senator Kennedy's position in our Congress and the roles he plays in the development of National Health Policy. We thus are fortunate to be able to hampdenize his message. The concept of a National Health Service Corps scholarship to help provide physicians in rural or inner city areas of physician deficit is a good one. As physicians we are aware of the cost of a medical education (especially if you are putting a daughter or son thru). We are just as aware that most of our patients could not afford to do the same and the minority groups from the lowest socio-economic levels never even make the college level. Thus thru our tax dollar, we can provide a route of access for the intelligent, motivated, dispriveleged would be physician. The specialty maldistribution is a bag of worms and Senator Kennedy seems to feel that the go slow approach is best for now. His third manpower problem is the foreign-trained medical graduate. Physicians who have helped to bring American Medicine to its present high level, yet who have added a different meaning to American Medicine. The senator's proposals are to be studied and reflected upon; they would limit the flow of FTMG's into the country. The Hampden Hippocrat, through its Letter to the Editor section, will be glad to print arguments for or against Senator Kennedy's strategy. The last provision of the Manpower bill deals with occupational health—a part of the new frontier for American Medicine. Industrial and self pollution if they can be minimized will go the longest way in assuring the American citizen of continued good health until he dies. Both the states and the federal government must take greater issue in this area.

Several other points in the manuscript need to be highlighted. Nationwide licensure can create a uniform level of medical competence—either high or low. Each state still should have the ability to regulate the inflow of professionals it registers and licenses. Feedback from organized medicine to the Board could indicate that a shortage or oversupply of a given speciality existed within the state which might help to keep the sunshine states with enough physicians and the others from losing their investment and physicians. Senator Kennedy points out that physicians must regulate themselves and maintain competence in their fields of endeavor. The Editor is sure that all physicians agree with the Senator. Medicine throughout the ages has always led in such actions; it has always culled out the quack and the incompetent. There is no

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reason to assume we should not be doing the same today. We lacked the means to prevent these from practicing—the new Board of Medical Registration and Discipline corrects and provides some of the means to keep our house in order.

The Editorial Board thanks the Senator for his efforts on our behalf; it invites its readers to write letters of agreement or rebuttal. For such is the stuff of American Medicine that new or old ideas can be discussed in the forum of the printed page and the truth derived therefrom.

The final manuscript comes via our president, through Mr. Owen Connally the administrator of the Providence Hospital and represents a distribution to hospital administrators and architects in the state. The Editor is not sure why this is a Bicentennial Plea, but it is appropriate. Doctor Fielding may have knowledge of the "plea" but he was not aware that it would find its way into the Hampden Hippocrat along with his article. The Plea does reflect the feelings of another professional's attitude toward state control via regulations.

The Hampden Hippocrat is your society's bulletin—your contributions, letters or complaints help to make it a readable worthwhile publication. Without your input, it dies or mummifies. So please contribute or complain!

The Editor-in-chief

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October Issue - 24 September, Friday

November Issue - 29 October, Friday

December issue - 19 November, Friday

January issue - 31 December, Friday

Manuscripts should be typed, on standard sized paper, and doubled spaced. Two and one half pages results in a single full page of published article. Associate Editors have been given standing assignments. If you have material, please forward it to the appropriate editor.

Quotes; From A Red Book

"The disorganization of American medicine will be achieved by lack of physician unity and regulation in the name of the public good. Dividing we conquer them."

"The physician cannot cope with bureaucracy: keep adding to his required reports."

"To achieve socialized medicine, promise total care to the citizen and a good living to the physician."

"Only the man who is secure and has everything can take the time to give other people's substance away. The man with little is content to share: the man with all will not. So give a little to all and soon no one will have anything."

From the red book on the downfall of American Medicine-1980

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